MDS-ALS TRAINING

Updated October 2011

WHAT IS THE MDS-ALS?

- A multi-page assessment developed to show an accurate "picture" of the Resident's condition and level of care needed
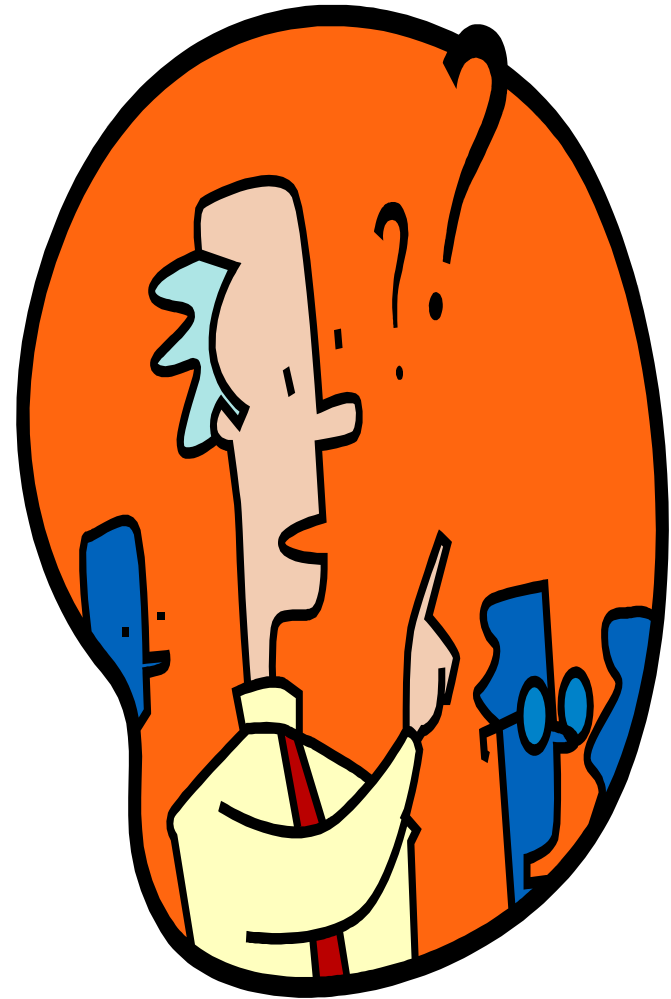
WHERE is the MDS-ALS used?

U̲ll Adult Family Care Homes

(Level III/IV RCF)

WHO????

- EVERY resident, REGARDLESS of payment source, must be assessed, using the MDS-ALS form

WHEN????

- Initial Assessment—Within 30 days of admission.

- Semi-Annual Assessment—Within 180 days of Initial/Annual (Based on the date at Item S.2.B on the MDS/ALS)

- Annual Assessment—Within 180 days of Semi-Annual Assessment (Based on the date at Item S.2.B on the MDS/ALS)

- Significant Change Assessment—Within 14 days after determination is made of significant improvement or decline in functional status (Details later)
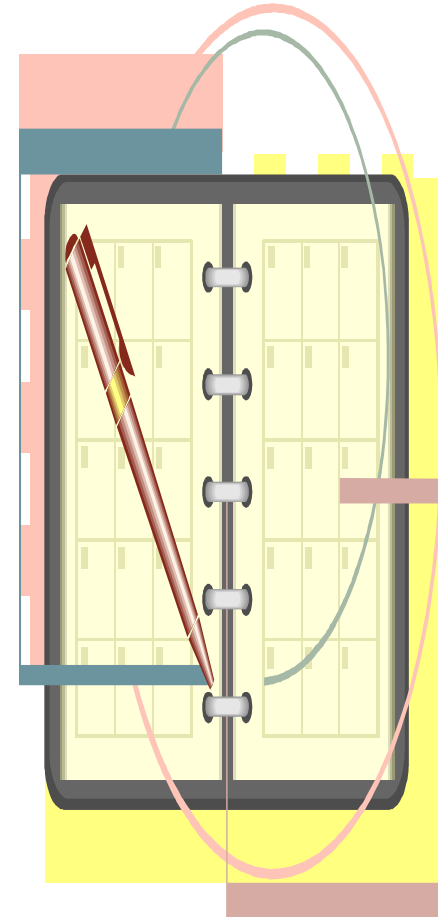
Accuracy of Assessments

- Only <u>staff trained by DHHS</u> may conduct or coordinate assessments.

- Each staff completing a portion of the assessment, must sign & date the MDS-ALS, certifying accuracy.

- State of Maine Regulations **require documentation to support the time periods & information** coded on the MDS-ALS.

- Sanctions may be imposed by DHHS for willfully/knowingly certifying false statements on the MDS-ALS.

Accuracy (continued)

- DHHS has the right to review all forms, documentation & evidence used for completion of the MDS-ALS at any time. Quality review will be completed periodically by DHHS Health Services Consultants.

- All Assessments & tracking forms must be <u>submitted</u> to DHHS <u>within 30 days of completion</u> (based on the date at S2b on the MDS-ALS).

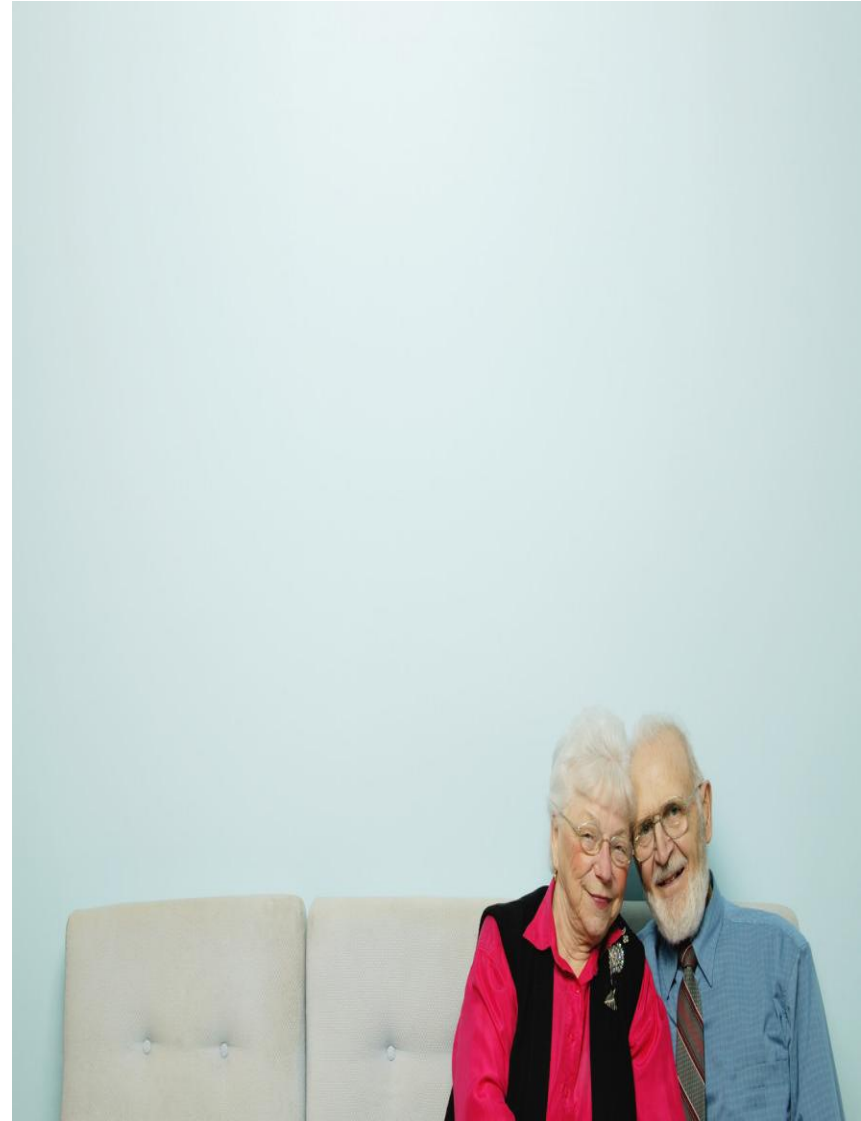- See MaineCare Benefits Manual, 10-144 CH. 101, Chapter II, page 8.

Development of the MDS-ALS

- OBRA
  - (Omnibus Budget Reconciliation Act)
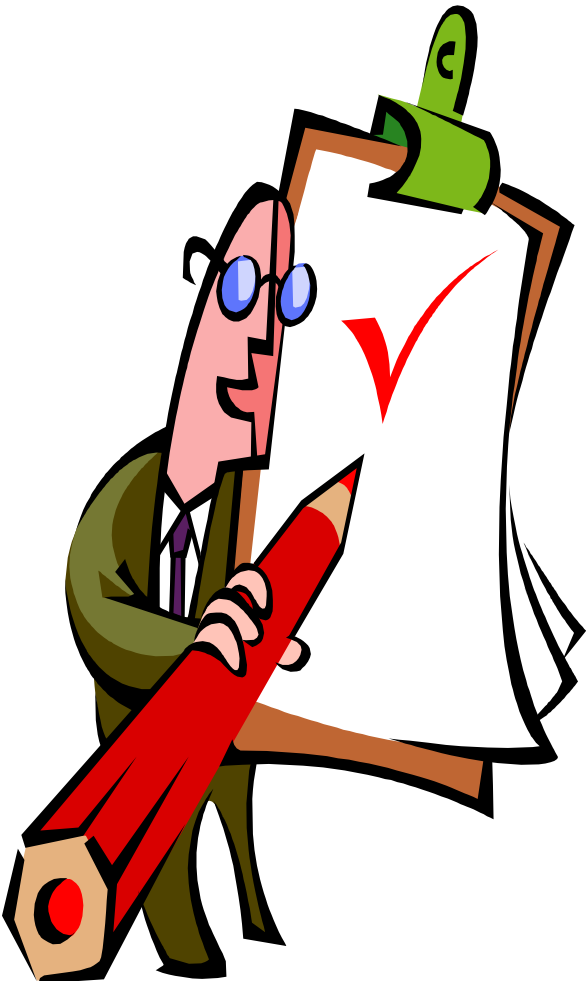
OBRA OBJECTIVE

- <u>All</u> citizens have the RIGHT to a dignified existence and to have care that permits one to attain or maintain ones highest degree of physical, mental and psychosocial well-being.

MDS History

- 1987:   Federal Mandate for NF Level (OBRA)

- 1990:   MDS implemented at NF Level (Including Case Mix Payment)

- 1995:   MDS-RCA implemented in Level IV Residential Care Facilities

  (Including Case Mix Payment)

- 2004:   MDS-ALS implemented in Level III Adult Family Care Homes (AFCH)

- 2008:   Case Mix Payment implemented in Level III/IV AFCH

- 2010:   Sanctions were instituted in Level III/IV AFCH

Why the ALS Assessment?

- Developed to show an accurate "picture" of the resident's condition and level of care needed.

- Helps in developing a realistic Service Plan.

- Used as a "payment source" for MaineCare residents.
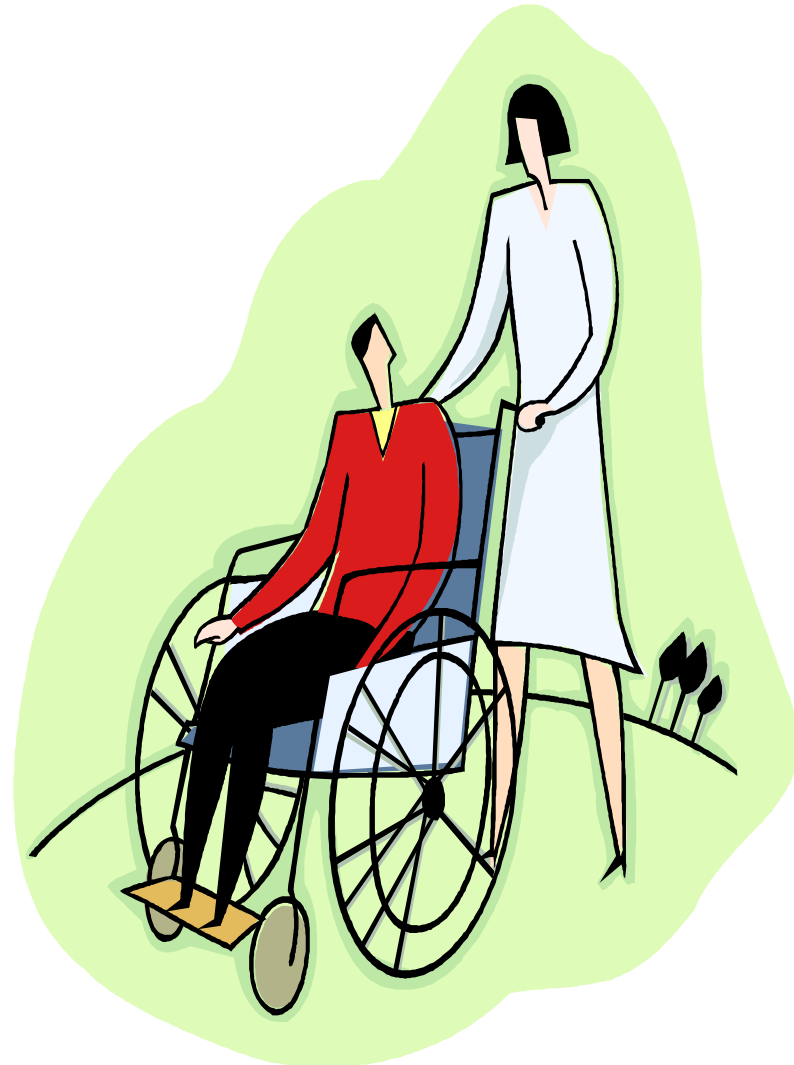
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ALS Assessment
├── Accurate "picture" of resident
│   └── Service Plan Development
│       └── Good resident care
└── Case Mix Payment
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Service Plans

- "Providers must develop and implement an individual Service Plan for each member. . .based upon the results of the assessment. . ."

- The Service Plan needs to "contain long- and short-range goals (as appropriate). . ."

ALS Definitions

- Assessment Reference date (**ARD**)
  - This is the **last day** of the time the resident was **being assessed**. All time frames for ALS items are counted back from this date.
  - The entire 24 hours of the ARD should be included on the ALS assessment (i.e. review documentation from the shifts after you left the facility on the ARD to see if anything occurred that should be coded on the ALS.
  - **Supporting documentation** for payment items **must be written during the time frame** for each item.

MDS-ALS Definitions

EDITING

This is when you review the completed MDS-ALS form for:

-<u>accuracy</u> of information and that directions were followed

-<u>legibility</u>

-<u>missing responses</u>

-<u>inconsistencies or omissions</u>

PAYMENT ITEMS

- Certain services and conditions that are on the ALS. They place a resident into one of 7 Resource Groups.
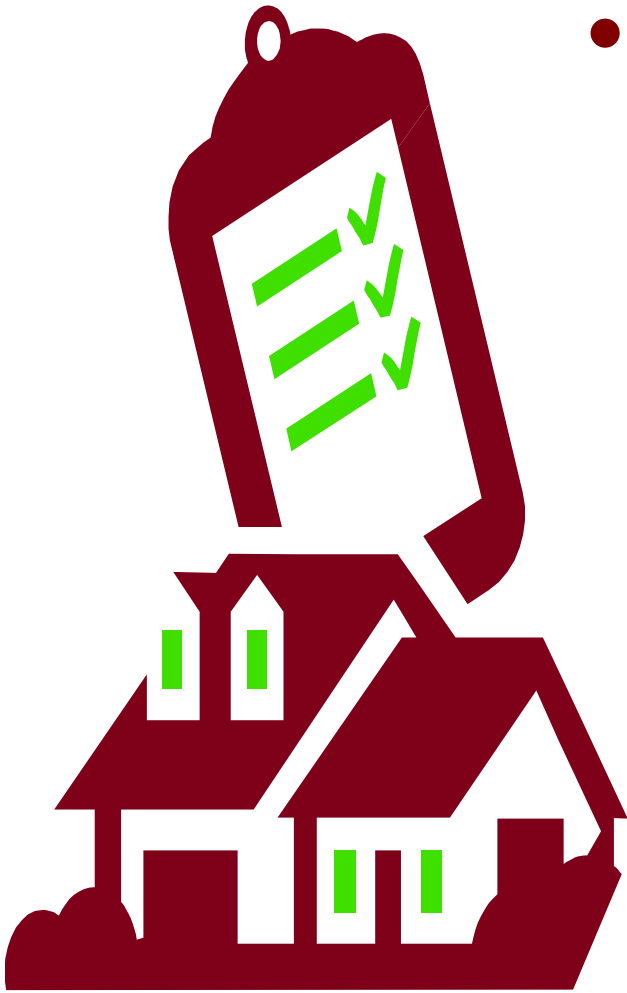
Resource Utilization Groups (RUGS)

- Residents are "grouped" by combining Clinical, IADL & ADL information.

- Residents in each group have **similar direct care time requirements** (based on results of time studies).

ROSTERS

- These are "lists" of residents at each Facility which include Case Mix information, produced from the most current MDS-ALS assessments submitted by the facility to the State.

Significant Change Criteria

- Major change
- Not Self-limiting
- 2 or more areas of decline or improvement
- Requires review and/or revision of Service Plan

What Is Case Mix ?

- Case Mix is a system of reimbursement that pays according to the amount of time spent with each resident.

Case Mix Payment System

- Facility is paid for direct care services based on the acuity and required care of the resident, as indicated on the MDS-ALS, 2 times per year (State assumes the MDS-ALS was completed correctly).
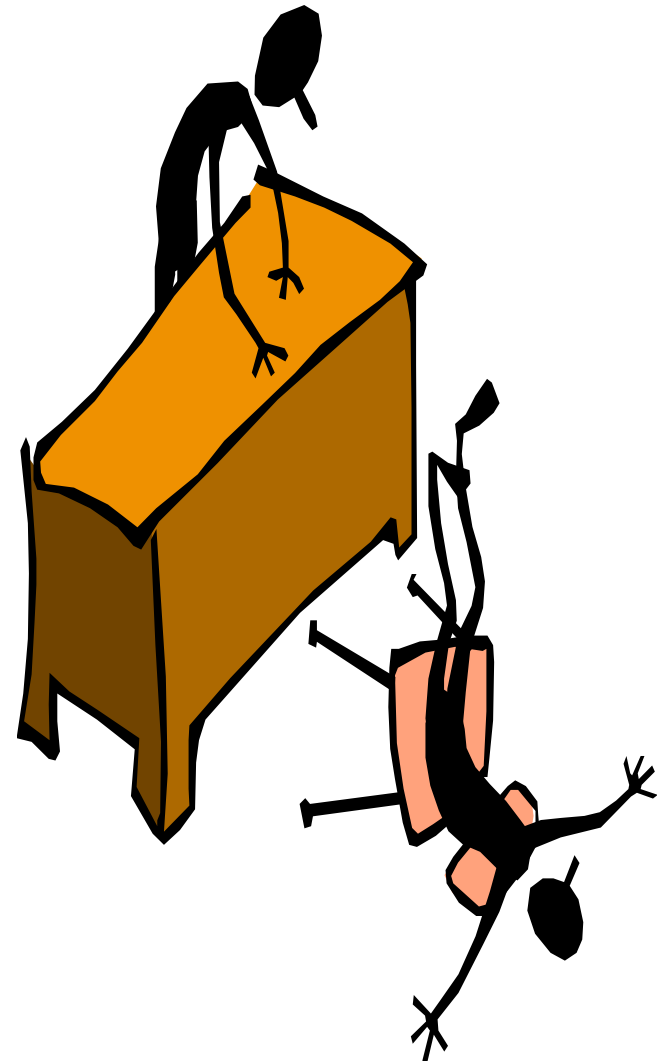
MDS-ALS
Resource Classification
# Tree Diagram

(See Handout)

RUGS

- Based on the information in the ALS, the resident "falls" into 1 out of 7 classification groups (or into the "unclassified" group if the form was not completed according to instructions)
  - Residents in **each group** have **similar direct care time requirements**—based on time studies
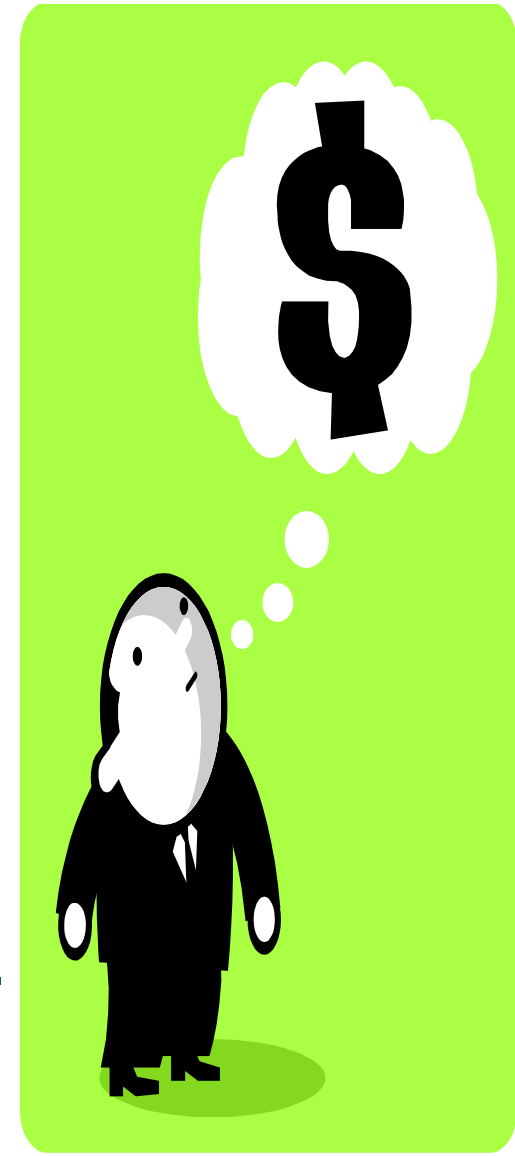
Payment "Weights"

- Each "Group" has a payment "weight" assigned to it—since the "group" varies from resident to resident, this is referred to as "Case <u>Mix</u>."

  - **The Facility gets paid this rate multiplied by the base pay rate, plus a "program allowance" for each MaineCare resident.**
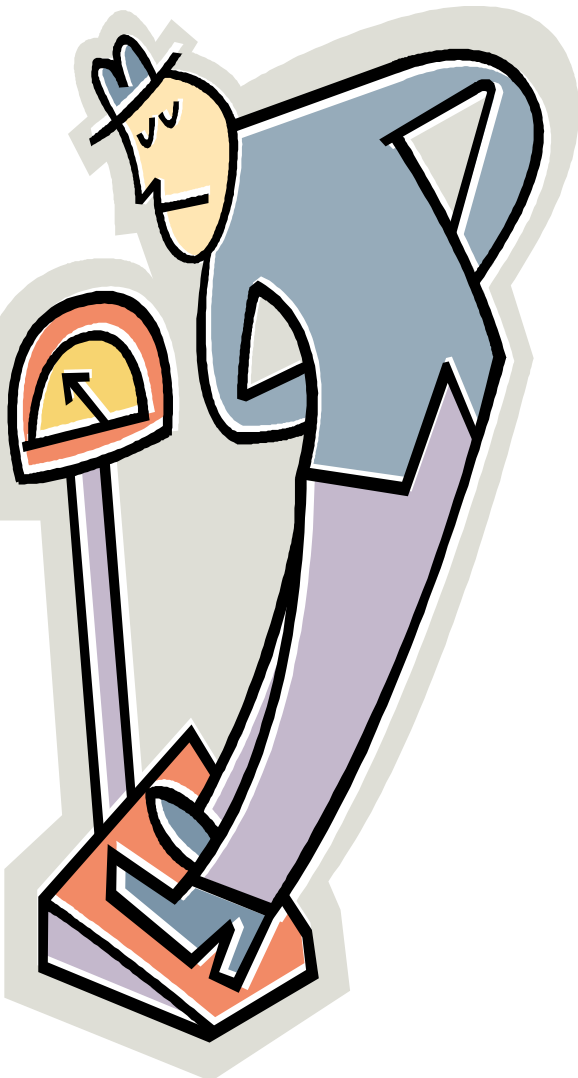
How Does Case Mix Effect a Facility?

- Facilities can increase their reimbursement by admitting those residents whose care requires more of the staff's time. These residents are considered "higher acuity."

- Higher acuity residents include those with Alzheimer's or other dementia, those dependent for assistance with Activities of Daily Living and/or Instrumental Activities of Daily Living, and those with mental health problems.
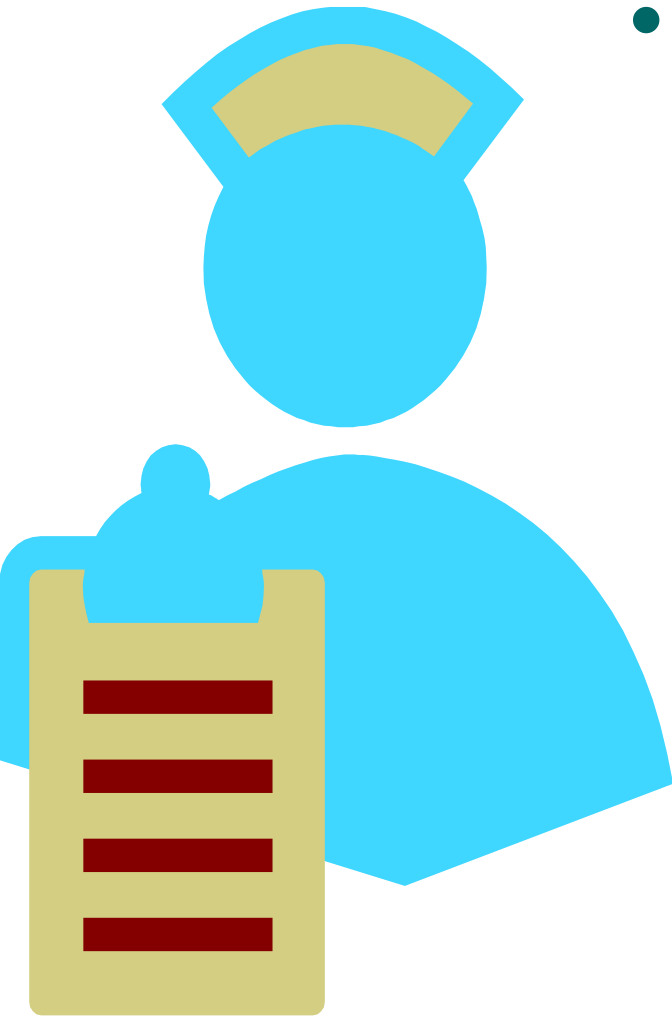
PAYMENT MAXIMIZATION

- If a resident meets the criteria for more than one group, the resident will automatically be placed in the higher weighted group for reimbursement
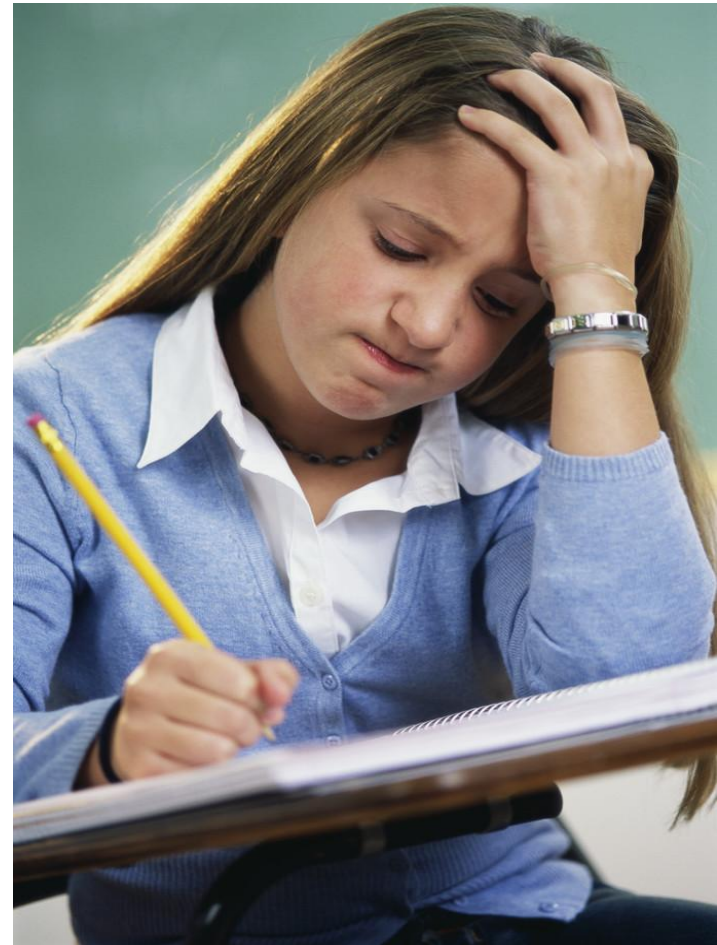
QUALITY ASSURANCE REVIEW

- Once every 6 months, a State Case Mix Nurse Reviewer examines a designated number of ALS assessments & resident records to check the accuracy of the ALS assessments.

What is an MDS-ALS Error?

- Inaccurate, too little documentation or no documentation to support the information coded on the ALS.

So poor documentation could mean. . .
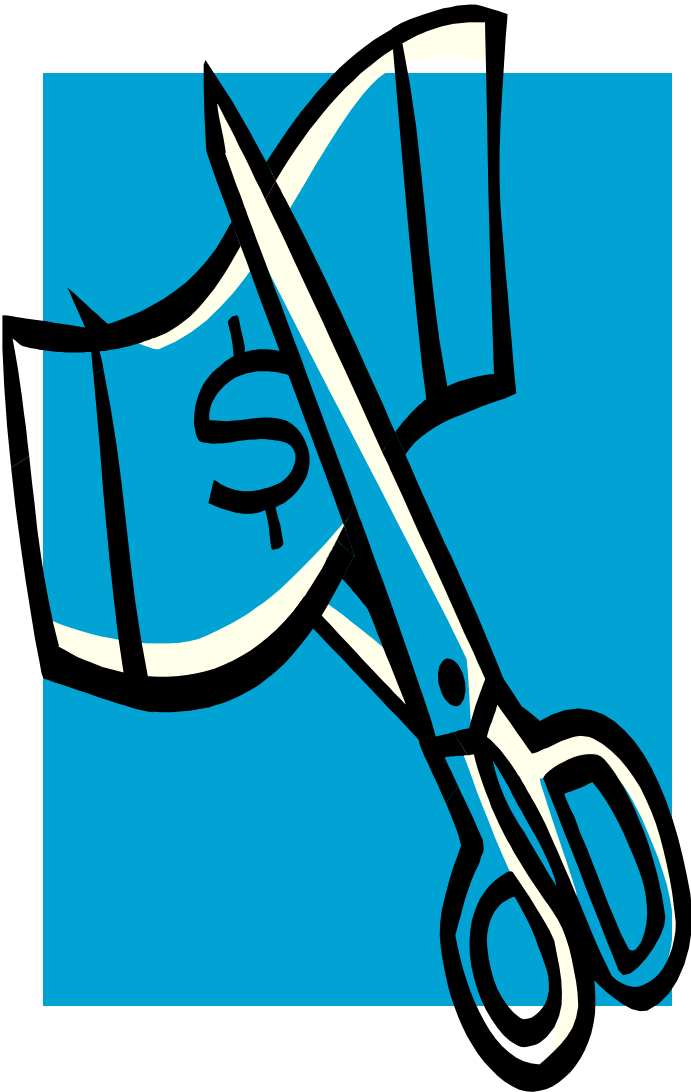
- Lower payment to the Facility because everything that would show a complete "picture" of the resident wasn't documented.

OR. . .

- The Facility is sanctioned (must pay money back to the State) because of errors (could be caused by inaccurate documentation, no documentation or, not enough documentation).

MONETARY SANCTIONS

- 34-<37% error rate=2% sanction

- 37-<41% error rate=5% sanction

- 41-<45% error rate=7% sanction

- 45% or greater=10% sanction

APPEAL PROCESS

- Found in the Maine Medical Assistance Manual, Chapter 1, Section 1, General Administrative Policies & Procedures, Number 1.19.

ANY QUESTIONS?

- About Case Mix payments or sanctions?

BREAK TIME

Completing the MDS-ALS

- Collect information to complete the MDS-ALS from a variety of sources.

- Collect information from the medical record, but observe and interview the resident for yourself.

- Collect information by interviewing caregivers, family members, or anyone who interacts with the resident.

- Supporting **documentation** is **required** for the **payment items**

Accuracy of the MDS-ALS

- Always complete the MDS-ALS as accurately as possible.

- If supporting documentation is inaccurate, **do not** complete an inaccurate MDS-ALS using that documentation.

- Pay attention to the timeframe in each section of the MDS-ALS. Timeframes are always the **last 7 days unless specified otherwise.**

Confidentiality

- The person completing the MDS-ALS is responsible to maintain the confidentiality of all information collected.

- Reassure the resident that any information he or she supplies about themselves is confidential.

- Conduct interviews in a private area in a confidential manner.
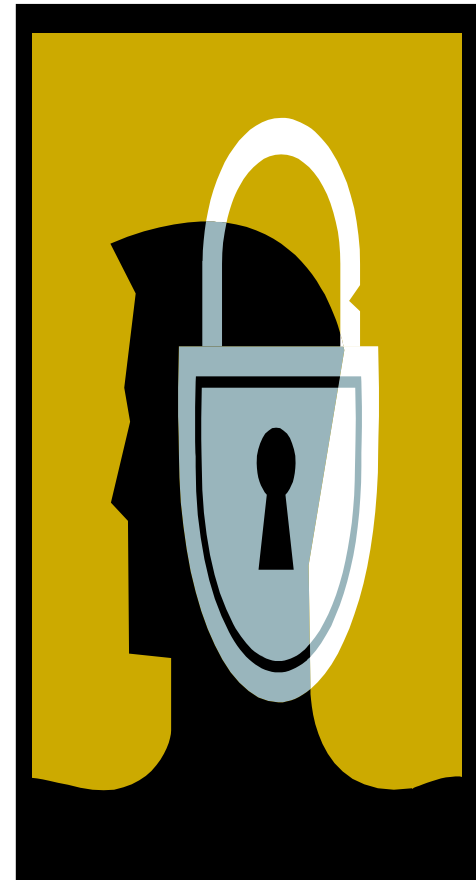
Discharge Tracking Form

- Sections
  - D1 Identification Information

  - D2 Demographics

  - D3 Discharge Information
    - Must be completed within 7 days of the discharge, transfer or death of the resident.
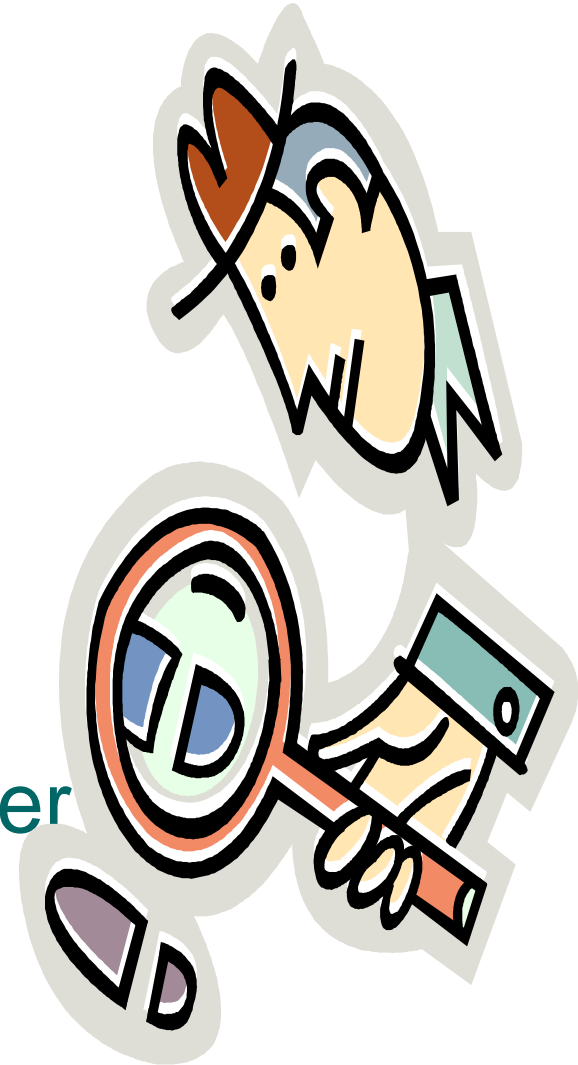
FULL ASSESSMENT FORM

- We will be **concentrating** on the Case Mix **payment items** today, however, if you have questions about any other item on the MDS-ALS form, please feel free to ask.

Documentation Requirements and Possible Record Location for Payment Items on the ALS

(See Handout)

FACE SHEET
(demographics)

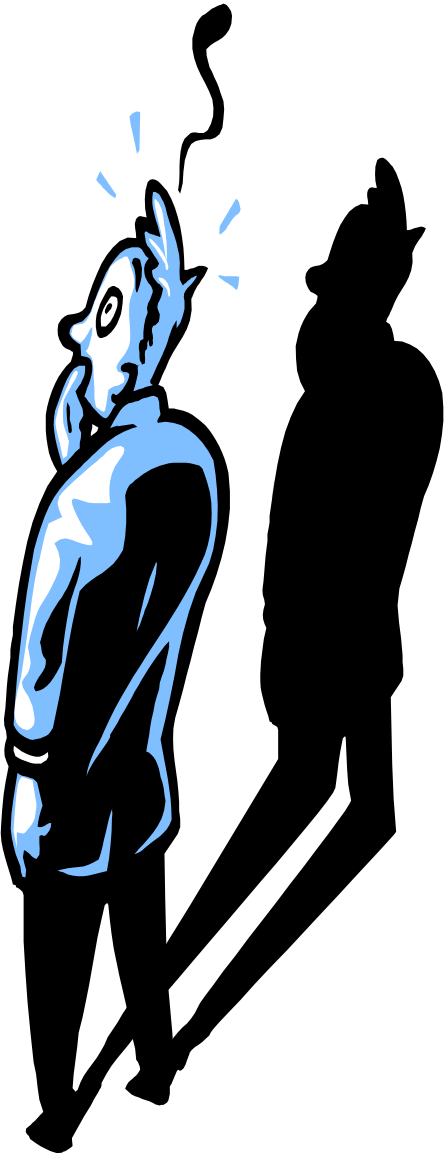- Complete & print on **admission only & leave in chart**.

  (Re-do only if changes are made)

ITEM BY ITEM

- **Payment items only unless** there are questions about other sections

ITEM B3

- Code of >0 on the ALS may place the resident in this payment group.
  - Documentation of impairment is required (per ALS Manual: "examples must be found in the record of resident's ability/inability to actively make decisions regarding tasks of daily living")
  - Code ALS for the "most representative level of function. . .use clinical judgment to decide whether a single observation is representative of the resident's typical level of function."

Section E

- E1=Indicator must be documented as occurring AT LEAST four (4) **times** in the last 30 days in order to code "1" on the ALS **or** 6-7 days <u>each week</u> to code "2."

  - Per ALS Manual: "Evidence and observances of these indicators must be present in the resident's record within the time frame"

Indicator's of Depression

- See Handout (Note the following similarities)
  - E1b Repetitive questions vs. E1c Repetitive verbalizations
  - E1d Persistent anger   vs. E1j Unpleasant in morning
  - E1f   Unrealistic fears   vs. E1g Statements of foreboding
  - E1l   Sad, pained face   vs. E1m Crying/tearful
  - E1o Withdrawal   vs. E1p Social isolation

  - Note: Code the ALS for E1o and/or E1p ONLY if it is a change in the Resident's usual pattern of behavior

Section G

- ADL Levels
  - Independent: No help or oversight (set up help is included here)
  - Supervision: Oversight, cueing or encouragement

    (i.e. **verbal help only**)
  - Limited: <u>Non</u>-weight bearing assistance
  - Extensive: <u>Weight bearing</u> assistance
  - Total: **Full staff performance** of the activity (staff should document this level only if "total" occurred for the entire shift)
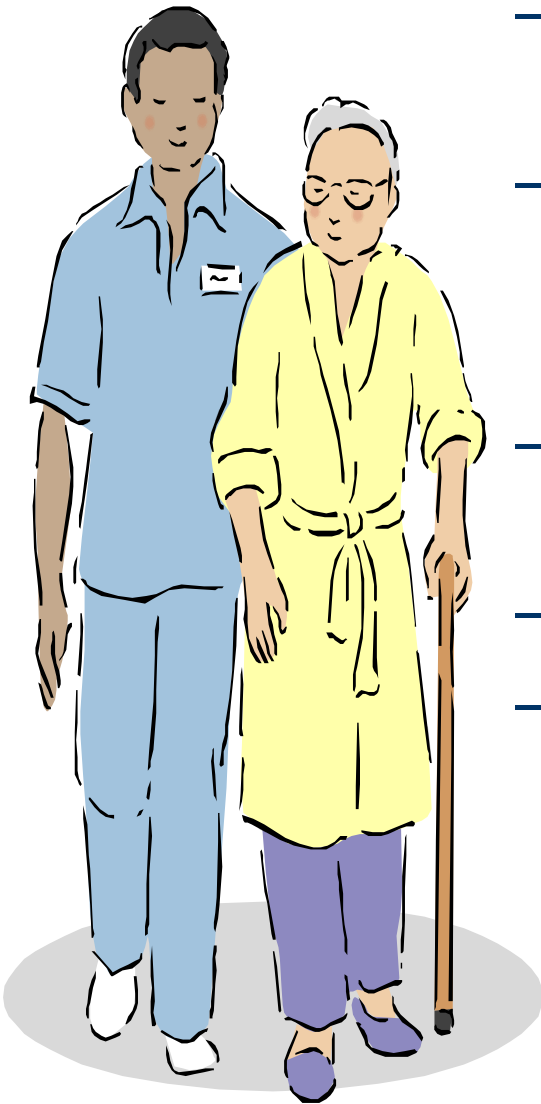
Coding ADLS on the ALS

- G1Aa-g
  - Code for resident's level of self-performance—must be documented as occurring **at least 3 times** in the 7-day "look-back."
  - Code **"8"** if activity documented as "did not occur" **all 21 shifts**.
  - Code **"4"** if "total care" or "8" is documented **all 21 shifts**.

Enteral Feeding

Tube Feeding

100%=Code 4 for self-performance and 2 for one staff assist.

If in addition to the enteral feeding, some solids/liquids are consumed by mouth, code 3 for self-performance and 2 for one staff assist.

Bathing

- G2: Code the ALS for the Residents level of self-performance/need for assistance
  - 0=Independent (includes assist with back & hair)
  - 1=Supervision (verbal assist only)
  - 2=Assist limited to transfer only
  - 3=Assist needed in part of bathing
  - 4=Total assist needed
  - 8=Activity did not occur in the last 7 days

Instrumental Activities of Daily Living (IADL's)
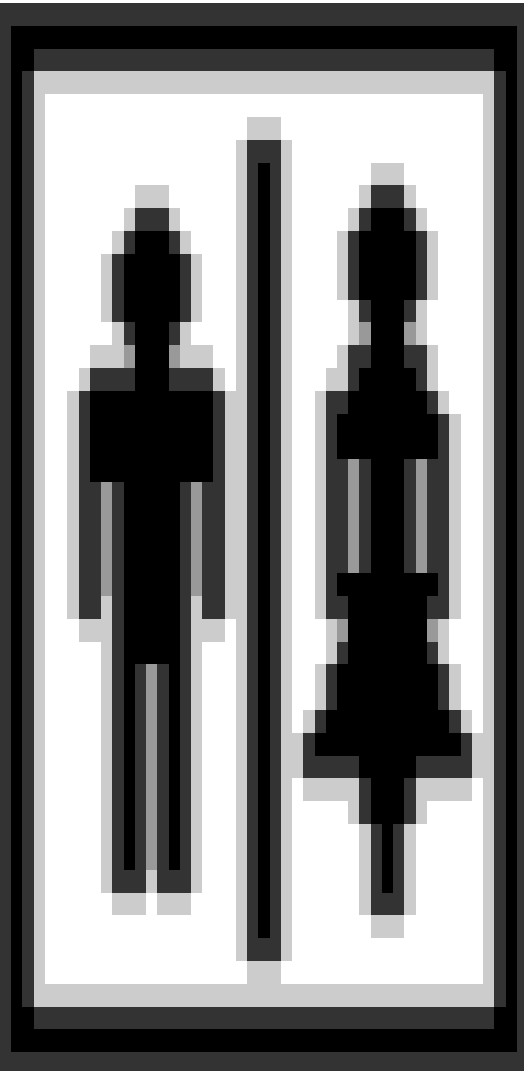
- G5A: Code ALS for Resident's level of <u>self-performance</u> in the last 30 days
  - a. <u>Arranging</u> shopping
  - b. Shopping
  - c. <u>Arranging</u> transportation
  - d. <u>Managing</u> finances
  - e. <u>Managing</u> cash
  - f. Light meal/snack <u>preparation</u>
  - g. Telephone
  - h. Light housework
  - i. Laundry

Coding for the IADL

- For each item in G5A, Code the ALS for the Resident's self-performance level in the last 30 days (Manual, page 70-73):
  - 0=Independent
  - 1=Done with help
  - 2=Done by others
  - 8=Activity did not occur

    - Per the ALS Manual, "Check the answer box that <u>best represents</u> the client's functioning during the past 30 days."

Incontinence Supplies

- H4 Code the ALS for the Resident's level of self-performance in <u>managing</u> incontinence supplies **(once the supplies are in the facility):**
  - 0=Always continent
  - 1=Resident incontinent & manages supplies independently
  - 2=Resident incontinent & requires assist with managing supplies
  - 3=Resident incontinent & does not use incontinence supplies (e.g. Resident refuses to use supplies or hides their soiled garments).

Definitions needed for medication administration

- Administer: The act of passing/giving medications to yourself or another person

- Prepare: The act of making sure that the medication being passed/given, is the medication that the person wants and/or that the physician has ordered

Self-Administration of Medications

- **O5f** Over-the-Counter (OTC) medications

  – Check this box if the resident self-administered ANY OTC medications in the last 7 days (even if staff prepared the medication)

  – Reminder: Some medications, such as 81mg Aspirin, Tylenol, cough syrup, etc., are OTC, even though the resident has a Rx
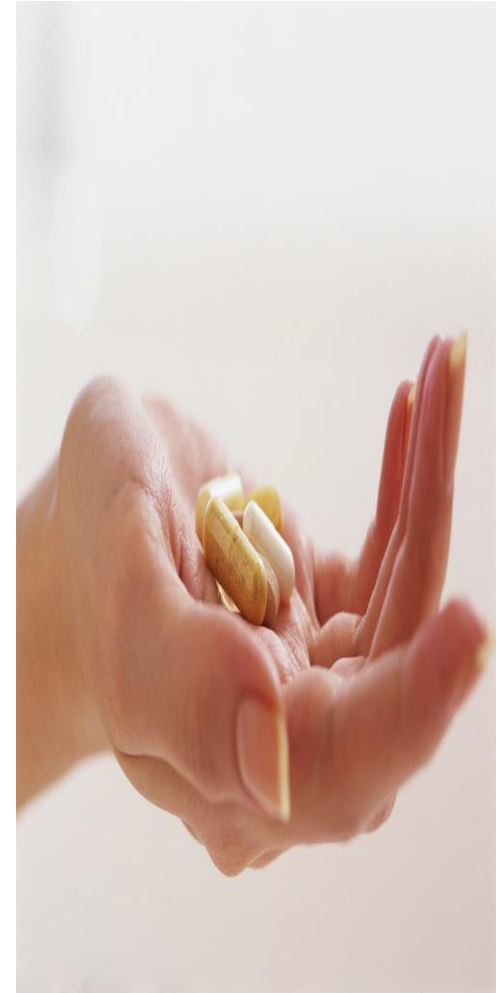
Medications (continued)

Item O6 Did the **resident prepare & administer** his/her medications in last 7 days

If the **resident is** responsible & has a physician's order to be **totally** responsible for preparing AND administering ANY of his/her medications, there must be documentation that this was actually done within the 7-days of the assessment period
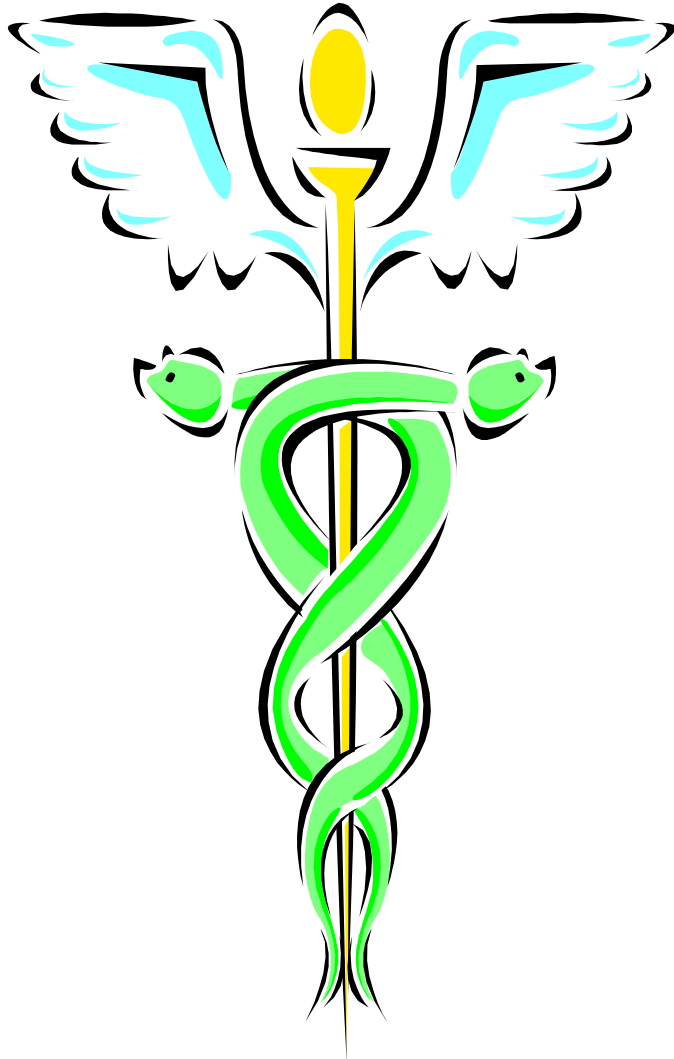
Medication Preparation & Administration

- 0=No Medications (Resident received NO medications in the last 7 days)

- 1=Resident prepared & administered NONE of his/her own medications

- 2=Resident prepared & administered SOME of his/her own medications

- 3=Resident prepared & administered

  ALL of his/her own medications

PHYSICIAN ORDERS

- (P10)—Enter the number of order <u>change</u> DAYS in the last 14 days:
  - DO NOT INCLUDE
    - Admission orders
    - Re-admission orders
    - Renewal orders without changes
    - Clarification orders without changes
    - Orders written by a pharmacist

ASSESSMENT COMPLETE

- S2a & b—MDS/RCA Coordinator signs & dates when the assessment is complete—(Be careful of timing for ARD & S2b)

- S2c thru e—All other Staff completing sections of the assessment sign & date here

Submission of MDS-ALS

- Submit completed assessments to:

  Catherine Gunn Thiele

  Residential Care Data Specialist

  Muskie School of Public Service

  P.O. Box 9300, 96 Falmouth Street

  Portland, Maine 04104-9300

  Tel. (207) 780-5576

- Effective January 1, 2012: Any Adult Family Care Homes who use an **approved** software system are encouraged to submit electronically through the new Submission Management System

NON-PAYMENT ITEMS (please review)

- B1, B2, B4 (Memory, Recall & Cognitive Status)
- C1-C5 (Communication/hearing)
- D1, D2 (Vision patterns)
- E2-E8 (Mood/behavior)
- F1, F2, F3 (Psychosocial Well-being)
- G1Ba-g, G1Ah, G3A-G4, G6-G8 (ADL/IADL)
- H1a-H3, H5 (Continence)
- I1& I2 (Diagnoses)

NON-PAYMENT ITEMS(continued)

- J1-J8 (Health Conditions)
- K1-K4 (Oral/nutritional status)
- L1 (Oral/Dental status)
- M1-M3 (Skin Conditions)
- N1 through N9 (Activity Pursuit Patterns)
- O1-O5e, O5g, O5h, O7 & O8 (Medications)
- P1-P9, P11 through P13

NON-PAYMENT ITEMS (continued)

- Q1, Q2 (Resident Goals)
- R1 (Discharge Potential)
- S1 (Participation in assessment)
- T1 (Preventative Health)
- U (Medication List)

ANY QUESTIONS?